JULY PROVIDER COUNCIL QUESTIONS

1. **The discharge OMS asks when was the discharge OMS completed, if the client leaves AMA or is deceased what date should we use? The system will not let you complete the discharge without a date.**

According to the OMS Interview Guide, located on the Beacon Health Options website at http://maryland.beaconhealthoptions.com/provider/forms/oms/OMS-Interview-Guide-Dec-2014.pdf, the discharge date entered should be reflective of the date that the client/child/adolescent is officially being discharged from the clinic. Please note that there is a place to enter the date of last contact with the client and this may be different from the client's discharge date. For more information, please review the guide under section D.

2. **The Governor's fiscal year 2019 budget included a 3.5% rate increase for community based behavioral health providers, but we have not seen any Medicaid rate sheets for FY2019. The Alert sent out recently contained only old rate sheets from 2016 and 2017 for Mental Health Providers. We are community-based behavioral health OMHC and MTS providers. Usually these rate sheets are available around March of each year for the new coming fiscal year. Is the new FY 2019 Maryland Mental Health Medicaid Rate Sheet available, and if so, when can we expect it?**

The Department erred in sending an old rate schedule to Beacon to include in the Provider Alert, however the rates that were shared with Beacon are correct and are loaded in their system. We apologize for the error and the correct fee schedule was shared as a provider alert on July 20th.

3. **Will there be any updates made in Beacon within client demographics to be inclusive of various gender identities other than Male/Female? In our PRP we are assessing and enrolling more transgender clients.**

Beacon's system is based on the MMIS system which is set to the Federal categories under Medicare which includes edits based on gender using only male/female categories. Recipients of Medicaid each have an eligibility file which includes gender and is based on a network of eligibility systems that need to match or could result in an individual being inadvertently dis-enrolled from Medicaid. The edits in these systems are also designed to prevent one gender from receiving a service that is only female (e.g. childbirth). If the availability of categories change or expand in the future, then MMIS could be updated which would also be reflected in the ASO's system.

4. **EMDR Coverage. At debugging meeting on May 18, the state agreed to determine whether a CMS/Medicaid prohibition against EMDR remains in place, as other state Medicaid programs cover EMDR for PTSD and an increasing number of Maryland clinicians are certified in this practice. Has this information been obtained?**

The Department has several priorities at this time, but will review what other states are covering under their State plans. We do not currently have an estimated time frame for reviewing this service.

5. **E&M Rates. The fee schedule released on July 1 contains no changes to the rates for E&M codes. On June 22, the Maryland Register contained a public notice indicating that physician E&M rates would increase. On March 30, the state proposed regulations reducing reimbursement for E&M codes by over 6%. Can you clarify whether E&M rates will increase? If so, when? Can you explain how the rates in the Maryland register align with the fee schedule?**

E&M codes are tied to the percent of Medicare and any changes made are reflected in the July 1st fee schedule. There was an increase in some E&M rates for July 1, 2018. The Department erred in sending an old rate schedule to Beacon to include for the Provider Alert. The correct fee schedule was shared as a provider alert on July 20th. The regulations are in the process of being updated and will be modified to remove any confusing statements.

6. **Health Home Rate. On June 22, the Maryland Register contained a public notice indicating that rates for health homes would increase 3.5%. Providers have not received an updated fee schedule or alert reflecting this increase. Is one forthcoming?**

The updated fee schedule can be found on the Health Home provider information website here: https://mmcp.health.maryland.gov/Pages/Health-Home-Requirement-Information.aspx. The new rate effective July 1, 2018 is $106.46 for both W1760 and W1761. An email alerting Health Home providers to the updated rate was sent out to each provider's main contact with MDH. If providers did not receive the communication, please email mdh.healthhomes@maryland.gov to be added to the list.

7. **E-Medicaid Functionality. Two providers – Arundel Lodge and Johns Hopkins Bayview – have recently reported continued difficulty with e-Medicaid functionality and are having difficulty submitting notes. Although providers prefer billing after notes have been submitted, these functionality problems have disrupted that workflow.**

a. Providers reporting problems to eMedicaid have been unable to get a timeframe for the problems to be corrected. Can you provide a timeframe for anticipated corrections to eMedicaid?

The Health Homes team, IT, and the providers are in daily to weekly communication about the eMedicaid technical problems. IT is actively working on a solution. Unfortunately, they are having significant programmatic issues and we do not have a timeframe for correction at the time.

b. Until the problems are corrected and providers are able to enter service data, could you suspend compliance audits until eMedicaid is fully functional?

We are aware of the ongoing eMedicaid issues and will not penalize providers for eMedicaid's technical errors. Providers may only bill Medicaid for individuals who received the minimum of two services for that month. Until the problems with eMedicaid are resolved, if providers are having consistent significant problems with eMedicaid they can contact mdh.healthhomes@maryland.gov to set up a process for manually sending us monthly services. As a reminder, all Health Homes services also need to be documented in the patient's files.

8. I think the date of service that I should bill for Code 90889/HG should be the date I submitted the Discharge Information Sheet and OMS (whether it is the full OMS when client is present or the abbreviated OMS when client is not present) into Provider Connect. Is this correct? Is the deadline for submitting retroactive claims midnight on July 13? For future discharges after July 13, must the Discharge be submitted to Provider Connect within 100 days of last visit (per 06-01-18 Provider Alert) OR within 30 days of client's last visit (per 04-13-18 Provider Council minutes)?

A discharge OMS summary is required to be done with the patient within 30 days of the last visit. While the interview must take place within that time frame, Providers have 100 days from the end date of the previous review to enter this discharge information or the system will revert to an initial request and they will be unable to go back and enter the data. BHA extended the date to July 20, 2018 for submitting the SUD OMS claims.